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**Part I Four categories defined by MIPS Correlate with**
**Four Strategies SETMA Defined in 2000-2005**
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**Your Life Your Health**
***The Examiner***
**October 13, 2016**

This is a three-part series which examines SETMA's work over the last twenty years and how it anticipated the categories of the MACRA and MIPS. While I personally like MACRA and MIPS, there are elements of its design which perpetuate past healthcare reform design flaws. This series examines those flaws and recommends means of resolving them.

The **four categories** defined by MIPS in **2015** correlate with the **four strategies** SETMA defined in **2000** for the transformation of our practice. In 2000-2005, SETMA established the belief that the key to the future of healthcare transformation was an internalized ideal and a personal passion for excellence rather than reform which comes from external pressure. Transformation is self-sustaining, generative and creative. In this context, SETMA believes that efforts to transform healthcare may fail unless four strategies are employed, upon which SETMA depends in its transformative efforts.

On October 6, 2016, I realized that SETMA's four strategies correlate with CMS' four categories for the determination of MIPS' Composite Performance Score. In bold face below, SETMA's four strategies for healthcare transformation are listed; following that in red are the MIPS categories which correlate with SETMA's strategies.

**SETMA's Strategies for Healthcare Transformation** – **MIPS Categories of Scoring System**

1. **The methodology of healthcare must be electronic patient management** – **MIPS Advancing Care Information** (an extension of Meaningful Use with a certified EMR)
2. **The content and standards of healthcare delivery must be evidenced-based medicine** – **MIPS Quality** (This is the extension of PQRI which in 2011 became PQRS and which in 2019 will become MIPS -- evidence-based medicine has the best potential for legitimately effecting cost savings in healthcare while maintaining quality of care)
3. **The structure and organization of healthcare delivery must be patient-centered medical home** – **MIPS Clinical Practice Improvement activities** (This MIPS category is met fully by Level 3 NCQA PC-MH Recognition).

4. **The payment methodology of healthcare delivery must be that of capitation with additional reimbursement for proved quality performance and cost savings** – **MIPS Cost** (measured by risk adjusted expectations of cost of care and the actual cost of care per fee-for-service Medicare and Medicaid beneficiary)

This is remarkable both in affirming our work over the past twenty years and affirming the rationale behind MACRA and MIPS. This realization came as the result of the writing of this article and twelve other articles about MACRA and MIPS.

Personally, I approve of MACRA and MIPS and think it is a step in the right direction, however, I think there are potential problems with the design of MIPS. Some of the rationale for my concerns are present in at the following link: SETMA's Model of Care Patient-Centered Medical Home: The Future of Healthcare Innovation and Change. The following is an explanation of this concern.

**Potential Hazard of MACRA and MIPS**

The most difficult thing about the new program is that there is not an absolute standard against which healthcare providers will be measured. Provider evaluation will always be a judgment made two years after the fact, I.e., you will practice and perform in 2017, but it will be 2019 before you know where you stand.

The biggest problem with this moving target is that you have to assume that everyone's results mean the same performance. That is not necessarily the case. It is possible that if everyone began to perform at a high standard that the distribution would be very narrow. The possibility exists that a person could be performing at a 95% level and still be a standard deviation below the mean which could result in a penalty for a performance which everyone would consider excellent.

Larger organizations and/or duplicitous organizations (the two are not synonymous) can find or use methods which meet the standard without achieving the excellence of care implied by the measurement. The possibility of organizations focusing on intentionally meeting a few metrics could result in a high level of performance on this artificial metric without a significant improvement in care or outcomes. This concern was present twenty years ago when SETMA began designing our "model of care."

**Core of SETMA's Principles Not Adopted by MACRA and MIPS**

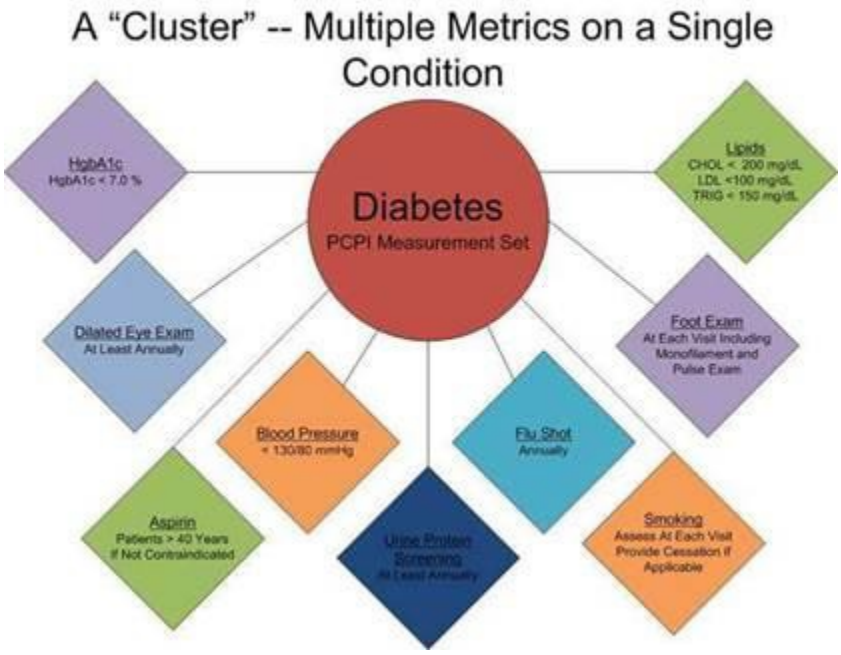
At the core of SETMA's four strategies described above is the belief and practice that one or two quality metrics will have little impact upon either the processes or the outcomes of healthcare delivery, and, they will do little to reflect quality outcomes in healthcare delivery. In the Centers for Medicare and Medicaid Services (CMS) mandatory Physician Quality Reporting System (PQRS), which in 2011replaced the voluntary Physicians Quality Reporting Initiative (PQRI) healthcare providers are required to report on nine quality metrics of the providers' choice, but this requirement will be reduced to six quality metrics under MIPS in 2019.

SETMA argues that this is a minimalist approach to providers quality reporting and is unlikely to change healthcare outcomes or quality. The following discussion gives more detail about this assertion.

SETMA currently tracks over 200 quality metrics, but this number does not tell the whole story. SETMA employs two definitions in our use of quality metrics in our transformative approach to healthcare:

- A "cluster" is seven or more quality metrics tracked for a single condition, i.e., diabetes, hypertension, etc.
- A "galaxy" which is multiple clusters tracked in the care of the same patient, i.e., diabetes, hypertension, lipids, CHF, etc.

SETMA believes that fulfilling a single or a few quality metrics does not change outcomes, but fulfilling "clusters" and particularly "galaxies" of metrics, which are measurable by the provider at the point-of-care, can and will change outcomes. The following illustrates the principle of a "cluster" of quality metrics. A single patient, at a single visit, for a single condition, will have eight or more quality metrics fulfilled, which WILL change the outcome of that patient's treatment.




But the "real" leverage comes when multiple "clusters" of quality metrics are measured in the care of a single patient who has multiple chronic conditions. The following illustrates a "galaxy" of quality metrics. A single patient, at a single visit, with multiple "clusters" involving multiple chronic conditions thus having 60 or more quality metrics fulfilled in his/her care, which WILL change the quality of outcomes and which will result in the improvement of the patient's health. And, because of the improvement in care and health, the cost of that patient's care will inevitably decrease as well. The following illustrates a "galaxy."


SETMA"s model of care is based on the four strategies described above and on the concepts of "clusters" and "galaxies" of quality metrics. Foundational to this concept is that the fulfillment of quality metrics is **incidental** to excellent care rather than being the **intention** of that care.

**MIPS and SETMA – Public Reporting**

In 2008, SETMA adapted Business Intelligence software to be able to analyze and report provider performance on hundreds of quality metrics. Beginning in 2009, those reports were posted by provider name on SETMA's website. At the writing of this article, there 7 ¾ years of results by provider name posted at www.jameslhollymd.com link: http://www.jameslhollymd.com/public- reporting/public-reports-by-type.

Another MACRA requirement is that each physician's MIPS composite score will be posted to the Physician Compare website, along with the physicians' score in each of the four performance categories. This is another element of the new law which was anticipated by SETMA. Public Reporting by provider name of quality performance is an integral part of SETMA's Model of Care as described in Part I of this series in the following brief explanation: